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HEALTH CARE FACILITY

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FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1604	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/05/2010
NAME OF PROVIDER OR SUPPLIER MANCHESTER HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 395 INTERSTATE DRIVE MANCHESTER, TN 37355		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 832	<p>1200-8-6-.08(2) Building Standards</p> <p>(2) The condition of the physical plant and the overall nursing home environment must be developed and maintained in such a manner that the safety and well-being of residents are assured.</p> <p>This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to comply with the state building standards.</p> <p>The findings included:</p> <p>During the facility tour on 4.5.10 the following deficiencies were noted and verified by the Director of Maintenance.</p> <p>At 10:05 AM, observation of the DON office and the beauty shop revealed portable space heaters being used. Tennessee Department of Health 1200-8-6-.08(2)</p> <p>At 10:30 AM, observation of the outside electrical room revealed a light was burn out. TDOH 1200-8-6-.08(2)</p>	N 832	<p>N832</p> <p>Corrective action included removing the portable space heaters and replacing the burned out light. This action was completed on 4/5/2010 by the Director of Maintenance.</p> <p>The entire building was inspected for portable space heaters and burned out lights on 4/5/2010. Also, a staff inservice was completed 4/13/2010 to the Quality Assurance Committee to discuss this deficient practice.</p> <p>As for the measures put into place to ensure this practice does not recur, a staff in-service was completed on 4/15/2010 by the RN Nurse Educator regarding burned out lights and portable space heaters. Additionally, daily rounds will be completed Monday - Friday by the Director of Maintenance or designee. The rounds will continue weekly x4, monthly x2, and then quarterly</p> <p>As for monitoring to ensure deficient practice does not recur, all results of the rounds will be reported to the Quality Assurance meeting monthly for analysis of findings. The Quality Assurance Team consists of the following: Medical Director, Administrator, DON, QA Nurse, Staff Nurse Educator, Social Services Director, Dietary Director, Activities Director, Admissions Coordinator, MDS Coordinator, and Human Resources Manager.</p>	4/19/2010	

Division of Health Care Facilities

Rachel Anderson Administrator
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

4/19/2010

STATE FORM

6099

CHDZ21

If continuation sheet